VOLUME 2, NUMBER 6, NOVEMBER 1973

Family Planning Digest

A publication of The Bureau of Community Health Services, Health Services Administration, Department of Health, Education and Welfare.

Fertility

Income Maintenance Experiment Did Not Spur Families to Have More Children

Will income maintenance programs which provide payments for each child encourage couples to have more children than they would otherwise have had? In a controlled study of the effect of such programs on employment and earnings, the opportunity arose for measuring the effects on fertility. The study suggests that income maintenance plans do not affect the fertility of families receiving such assistance—at least over a three-year period. This was the duration of the experimental income maintenance program reported on by Glen C. Cain of the Department of Economics at the University of Wisconsin at the Population Association of America's annual meeting last April.

Cain noted that there was no increase in the fertility of nearly 600 white and nonwhite families in New Jersey and Pennsylvania enrolled in several experimental "negative income tax" plans which provided varying payments for each child in the family. Originally, 1,357 families (including at least one male aged 18-58 who was neither permanently disabled nor a full-time student, and at least one other family member), whose "normal household income" was less than 150 percent of the federal poverty level were enrolled in four communities. Some 95 percent of the households consisted of a husband, wife and one or more children, with an average family size of six.

Workers had fewer children than nonworkers, but payments did not affect childbearing of either group.

Of the total number of families in the study, 725 (or 53 percent) were put on income maintenance plans, using basic income guarantees ranging from 50 to 125 percent of poverty (the poverty line for an urban family of four was $3,300 in 1968 when the study began) and "implicit tax rates" (the amount of support a family loses for each extra dollar earned) of 30, 50 and 70 percent; the remaining families served as controls. However, because the number of families that broke up during the program was relatively large by the

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time data were analyzed (the thirtieth month) and because 20-25 percent of families dropped out of the study, the fertility analysis was based on 586 intact families — all with wives under 40 years of age.

The experimental programs, Cain reported, had "no significant effect . . . on the rate of pregnancy and births" as measured after the sixth, eighteenth and thirtieth months (the last one reported on), nor was there any "tendency . . . for the more generous plans to be associated with higher fertility than the least generous plans." For the latter two periods, in fact, white families receiving assistance had lower fertility rates than white control families, although the difference was not statistically significant.

Blacks' fertility and birth rates were slightly higher in the experimental group than in the control groups at all three time periods. This difference becomes statistically insignificant, however, Cain said, when the figures are adjusted for the fact that there was a "slightly larger number of pregnant black wives in the treatment group at the outset of the experiment" than among the controls. Cain reported that the Spanish-speaking families in the urban centers studied did not "exhibit the higher fertility that is usually associated with the same groups over the nation as a whole."

The higher the wife's educational and wage levels at the start of the experiment, the lower her fertility, the data show, while the husband's wage and education levels did not affect results. Whether the lower fertility of the working wife "is due to preferences, the long-run labor force attachment of the wife, birth control knowledge, or some other factor" was not known.

Theoretically, Cain explained, a pronatal effect was expected as a result of such programs. Because of allowances for each additional child (ranging from a high of from $437 to $1,093 a year for the first child to a low of from $146 to $365 for sixth and subsequent children, depending on the plan in which the family was enrolled) and because a significant portion of any wages the wife had been earning would be replaced by the assistance, both the direct costs of raising a child and the indirect costs (through loss of income) would be lower than without the program.

This was expected to produce an incentive for parents planning to have additional children at some future time to have them as soon as possible. And for those couples not desiring any more children, the cost of a contraceptive failure would be diminished. "It is as if there were a three year 'sale' period for various types of behavior," Cain said. However, "the response was null."

Cain's findings were supported to some extent by research reported on at the Population Association meeting by economist Julian L. and sociologist Rita J. Simon, of the University of Illinois. The husband-wife team surveyed married adults (76 percent of whom were women) by telephone, as to whether they thought they would have more children if the government paid them certain amounts (ranging from $25 to $300 a month) for each child after the second, and whether they thought the "average family" in their neighborhood would do so. The question was also turned around, and the respondents were asked what they thought would happen if a family had to pay the government similar amounts for each child after the second.

In separate surveys, 220 households in Illinois and 409 households nationwide were contacted. Eighty-nine percent of the former and 99 percent of the latter had children, and the median was two. Very few respondents said they would have more children for dollar amounts equivalent to those used in the New Jersey-Pennsylvania experiment. For $25 a month ($300 a year), only seven percent (three percent of those with incomes below $10,000) said they would have larger families. For $50 a month, between five and 14 percent (in different sampling groups) said they would have more children, 12 percent would do so for $75 a month, and between seven and 18 percent would do so for $100 a month.

The responses concerning the "average family" were significantly different from those concerning the respondents' personal behavior, however. At these levels of support, three to four times as many respondents felt an "average family" would have more children than they said they themselves would have. At higher levels of support, more people said they would have larger families themselves, but even at $300 a month—$3,600 a year—only 26 percent responded favorably.

The reaction to having to pay for larger families was more striking, even at the lower penalty levels. One-third of those questioned said they would have fewer children if they had to pay $25 a month for each additional child after the second. This was asked only of parents of three or more children. This figure rose to 53 percent for $300-a-month payments. Again, more thought the "average family" would react to such a program—46 percent expecting a response at the $25-a-month level, rising to as high as 79 percent for larger payments.

Sources

Papers presented at the annual meeting of the Population Association of America, New Orleans, La., April 26-28, 1973:

G.C. Cain, "The Effect of Income Maintenance Laws on Fertility: Preliminary Results of the New Jersey-Pennsylvania Experiment."

J. L. Simon and R.J. Simon, "The Effect of Money Incentives on Family Size: A Hypothetical Question Study."

Postcoital Contraception

Progestogens Work Morning After, Too

The contraceptive efficacy of five different dosages of a new postcoital pill containing a progestogen (D-norgestrel), but no estrogen, has been tested with more than 4,600 women in Lima, Peru. In higher dosages, the pill was reported as effective postcoitally as the standard progestin-only minipill taken over the entire cycle. [See: "Bleeding, Pregnancy Problems Found in Five Minipills Tested," *Digest*, Vol. 2, No. 1, 1973, p. 10.] While the lowest dosage of D-norgestrel used, 150 mcg per tablet, was ineffective, Dr. Esteban Kesserü and coinvestigators reported in *Contraception*, effectiveness increased with dose. For the highest dosage tested, 400 mcg, there was a general pregnancy rate of 3.5 per 100 woman-years of use including 1.7 pregnancies per 100 woman-years attributed to method failures.

The Food and Drug Administration (FDA), in approving two minipills (both with 350 mcg of norethindrone) for regular use throughout the cycle in the United States, noted that the pregnancy rate was

Family Planning Digest

Volume 2, Number 6, November 1973

A publication of The Bureau of Community Health Services, Health Services Administration, U.S. Department of Health, Education and Welfare. Prepared bimonthly by the Center for Family Planning Program Development, the Technical Assistance Division of Planned Parenthood-World Population.

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The Project upon which this publication is based was performed pursuant to Contract No. HSM 110-73-427 with the Health Services and Mental Health Administration, U.S. Department of Health, Education and Welfare.

The views expressed herein do not necessarily reflect the views of The Bureau of Community Health Services, Health Services Administration, DHEW.

approximately three per 100 woman-years. [See: "Progestin-Only Orals Approved by FDA," *Digest*, Vol. 2, No. 3, 1973, p. 4.] British and Yugoslav trials of a minipill with 75 mcg of norgestrel reported failure rates of about 2.0 per 100 woman-years. [See: *Digest*, Vol. 2, No. 1, 1973, p. 10 cited above.]

High doses of estrogen have been used as 'morning-after' pills. One of these, diethylstilbestrol (DES), has been approved by the FDA for this purpose, but the agency cautioned that it "be considered as an emergency treatment only." In more than 9,000 cases treated with DES or other estrogens at high doses, Dr. John McLean Morris and Gertrude van Wagenen have reported 29 pregnancies—only three of which were attributed to method failure. [See: "FDA Approves DES, Urges Limited Use," *Digest*, Vol. 2, No. 3, 1973, p. 12.] Use of high estrogen doses as a regular contraceptive regimen is contraindicated, the FDA noted, because of the risk of serious side effects.

Most of the 4,631 women in the Lima study were mainly from a lower-middle class section of the city, with the remainder from slum areas. They ranged in age from 15 to 48, with an average age of 28.7, and in parity from zero to 18 with an average parity of four. All had had at least one pregnancy and one-third of the women had had at least one abortion. Their average coital frequency was eight times a month. After a physical and gynecological examination, they were instructed to take one pill within three hours after every intercourse. Follow-up examinations were made every month at the start and every two months later in the study.

The following results were obtained with the various pills: The 150 mcg dose was soon dropped, since it resulted in a pregnancy rate of 45.2 per 100 woman-years (30.1 reported as method failures). For 699 women and 8,762 woman-months of use, the 250 mcg pill had a 6.2 failure rate (3.8 attributed to method failure); the 300 mcg pill, taken by 544 women for 4,085 woman-months, yielded a failure rate of 6.8 (3.8 due to method failure); the 350 mcg pill, taken by 559 women for 3,158 woman-months, showed a failure rate of 4.9 (3.10 due to method failure); and the 400 mcg pill, used by 2,801 women for 25,558 woman-months, yielded a failure rate of 3.5 (1.7 due to method failure). Coital frequency did not affect the failure rate.

Side effects were similar to those found with the standard minipill—primarily, unusual bleeding and irregular cycles. About one-third of the women had cycles of less than 20 days, and 10 percent had cycles longer than 45 days. There was no marked difference in these effects with the different dosages, the investigators noted, except for a slightly greater tendency for shorter cycles with lower doses and longer cycles with higher doses. Similarly, the women who took fewer pills tended to have shorter cycles, and those who took a large number of pills frequently experienced amenorrhea. Therefore, they suggested, it may be possible to use even higher doses of D-norgestrel (which should produce lower failure rates) "without major bleeding problems." Other side effects reported were headaches, nervousness and abdominal pain.

Drop-out rates from the program were high, but only between five and eight percent of the women discontinued for method-related reasons, the researchers said.

Source

E. Kesserü, A. Larrañaga and J. Parada, "Post-coital Contraception with D-Norgestrel," *Contraception*, 7:367, 1973.

Perfect Fertility Control

Later Marriage, Fewer Babies, Less Illegitimacy

What changes would occur in the roles of women and the nature of the family if perfect fertility control became a reality? Among other things, marriages and first births would be postponed, more women would get college educations and graduate degrees and more would become part of the labor force, family size would be reduced, there would be a greater diversity in life styles and more women would be voluntarily childless, theorizes Columbia University sociologist Harriet B. Presser. Her conclusions, first presented at the Conference on Population Growth and Policy in the United States last year, also appear in the recently published book, *Toward the End of Growth: Population in America*.

Perfect fertility control would mean that couples could have "as many or as few children as they want—when they want." Elimination only of "number failures"—having more children than ultimately desired—would reduce the number of births, she notes, since between 1965 and 1970 there were 2.65 million unwanted births to couples who desired no additional children, according to a "conservative" estimate of the Commission on Population Growth and the American Future.

The ability to control the timing of births (the 1970 National Fertility Study of ever-married couples showed that more than one-third of wanted births were timing failures) would have a profound effect on the lives of young women. Presser maintains that the "timing of the first birth . . . has the greatest potential for changing the roles of women." She observes that "the transition from no children to one child is more critical than the change to any parity of higher order, because having a first child . . . generally has a far more restrictive effect on a woman's daily activities than having an additional child."

The most obvious effect of delaying first births until they are desired would be the elimination of "most illegitimacy . . . and 'shotgun' weddings." In 1968, 16 percent of all first births in the United States were illegitimate, she points out, and a survey of married women in 1970 revealed that for one-third of them the first birth was a timing failure. "The perfect planning of the first birth would mean for many women, then, the postponement of marriage and motherhood, and, for some,

remaining single and/or 'child free' forever."

The ability to postpone the first birth will give many more women the opportunity to continue their educations and to explore occupational interests. "The broadening of options outside the home may reduce a woman's desire to become a mother, or a mother with many children." It should help cut family size.

While having more outside time may increase a woman's occupational and educational aspirations, the ultimate effect will depend on whether there is a concomitant rise in opportunities. The participation of young women in the labor market has been increasing consistently (44.9 percent of all women aged 20-24 in 1960, 56.8 percent in 1969), but the increase in professional jobs has not been as great, she notes. In 1960, 12.2 percent of working women held professional and kindred jobs, and this rose only to 14.7 percent in 1969. Continued "sex discrimination and unfavorable economic conditions [could] severely restrict the extent or level of female participation in roles outside the family," she adds.

Presser points out that "perfect fertility control does not suggest that all young women will wish to continue their education and seek careers outside the home," but it does mean that "more women . . . will have time to consider the options and experiment with them without unplanned interruptions." If experimentation reveals "that there are alternative sources of fulfillment aside from motherhood," the current norm that "having several children . . . [is] the primary source of self-esteem for women" would not remain in force, and "there would be an increase in 'appropriate' options" for women. Thus, more women would want no children or only one child since the social attitude that two or more children is 'normal' would no longer exist.

Not all women will opt for the new pattern, since "women who have been socialized from infancy for marriage and motherhood may experience the challenge to these roles with considerable confusion about their personal identity." But even for those women who do participate to a greater extent in nonfamilial activity, "the family will survive for some time to come because it fulfills certain needs which cannot, as our society is presently structured, be readily filled elsewhere." She points out that "men have been exposed to nonfamilial roles (and at higher levels of achievement than women)," but they still want to marry and have children. The changes that do occur in the nature of the family will probably concern "the role obligations of men within the family," Presser believes.

Currently, most women who work outside the home also have the "double burden" of working inside the home—a burden most men do not have. To some extent, this can be alleviated if men assume greater responsibilities in the home, which "we can expect . . . [them to do] so long as it does not threaten their non-familial roles." This should not cause fewer men to marry, since they would have the same responsibilities if they were on their own, but "the diversity of life styles and family-size desires may lead both men and women to postpone marriage."

This delay, accompanied by the elimination of premarital conception, could even "lead to greater marital stability," Presser suggests, since "unplanned marriages . . . precipitated" by such conceptions have a high divorce rate.

Current trends indicate that married women are having first births later, but illegitimate births are occurring earlier—since the only age group with a rising illegitimacy rate is that of girls aged 15-19. "Not only are there structural barriers that restrict the availability of effective birth control methods to unmarried teenagers, but many are not sufficiently motivated to practice contraception effectively," Presser declares. Since the most important factor in producing these changes in the role of women and in family life is "the problem of perfect fertility control prior to the first birth," there are "many problems to solve with regard to motivation" before these theorized effects will be seen.

Sources

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Communications

Tailoring Information and Education Material To Specific Audiences Is Crucial for Success

Before embarking on a family planning information and education (I & E) program it is essential that program operators determine who comprise the primary, secondary and tertiary audiences for such a program, and what are their most urgent specific informational needs, advises J. Mayone Stycos, director of the International Population Program at Cornell University. Stycos, a sociologist who has for years studied the family planning programs of many Latin American countries, and specifically, their informational content, urges that every informational and educational message be tailored to meet the precise and varying needs of each of the audience groups. While the focus of his study is on the experience in developing countries, many of Stycos' observations have relevance for the informational efforts of U.S. family planning programs. Given the economic and manpower constraints governing most family planning programs, Stycos believes that program operators should ask themselves the following questions as they examine their I & E efforts: How many resources are being allocated to each category at whom messages are being directed? What priorities should be established for I & E activities? How cost-effective is the I & E activity for each group?

Stycos believes that the primary audiences, with the highest potential receptivity to family planning, include clinic *first admissions and revisit patients*, followed by *postpartum patients* and *newlyweds*, whose receptivity may be more moderate. Low-income women (who may not necessarily be in the groups specified) are also a primary audience. Included in the secondary audience group are the program and government staffs directly involved in family planning. Both are highly receptive to I & E efforts. In the tertiary group with high receptivity are family planning program boards and officials directing government activities.

Stycos' observations on the messages addressed to some of the groups and his recommendations for improvement or change may be suggestive to those responsible for I & E programs in the United States. Of the primary groups he makes the following comments:

• *First admissions*. Women who come to a family planning clinic for the first time "are often the victims of too much rather than too little information." Much of it is "irrelevant and some of it is productive of anxiety. . . . Women come to clinics knowing what they want and it is not complicated: they want to stop having children. They want something that will do this without harming them. They do not care about reproductive physiology, demographic trends, responsible paternity, or sex education. They are nervous about what is going to happen to them, anxious to get it over with as quickly as possible, and in no mood to absorb a lot of information." What they need, according to Stycos, is reassurance, plus information about what side effects to look out

for and about why they should return to the clinic for regular follow-up. "In many clinics today, they do not get enough of the information they need, and get a lot they do not need instead." [See: "Clinics Teach Less Than Patients Learn," *Digest*, Vol. 1, No. 2, 1972, p. 13.]

• *Returning patients*. Since many patients never return for follow-up, the woman who does come back is obviously highly motivated. "This is the 'satisfied customer' so crucial to every successful sales campaign," Stycos points out. As such, she should be encouraged to act as salesperson for the program. This is especially important since "surveys invariably show that most new patients hear about the clinic by word of mouth, mainly from clinic clientele." [See: "How to Tell People About Family Planning," *Digest*, Vol. 1, No. 1, 1972, p. 6.] The author notes that since returnees "are usually subjected to considerable waiting periods in the clinic, the time could usefully be filled by teaching them how to spread the word about both the clinic and non-clinic sources of contraception. If there is additional time," he adds, "they could receive instruction, preferably automated, on reproductive physiology, maternal and child health [and] nutrition . . . matters of importance in their own right. . . ."

• *Postpartum patients and newlyweds*. Both groups are "motivationally receptive" to family planning education, and here the aim should be to sell the program. Postpartum patients are an "ideal group," since they are "conveniently agglomerated and relatively undistracted. Moreover, the act of maternity and the hospital setting makes explicit family planning information appropriate, where it might not be so for diffuse audiences." With newlyweds and new mothers the emphasis should be on "a 'spacing' goal." Stycos maintains that "a special advantage of reaching such groups is that they are still at an early point in fertility. . . ."

• *Low-income families*. Stycos notes that "the greatest number of potential clinic clientele" is among women of reproductive age who are in the lower income category, as in the United States. One of the major tasks of I & E programs is to identify or create special interest groups when families are "widely separated spatially, difficult to identify and have highly diffuse interests or characteristics." Since many low-income women work, efforts to reach them should be made through labor unions, factories or offices, and the large farms where, in the United States, they may work as migrant labor.

Of special relevance to the United States are Stycos' observations concerning family planning staffs, whom he views as a secondary audience of high receptivity to I & E, and boards of directors, described as a tertiary audience.

• *Staff*. While most staff members at all levels have been well trained in whatever technical matters they must handle, Stycos observes, "what has been almost totally neglected has been the area of interpersonal relations. Given the vast social distance between doctors and patients, the potentially traumatic experience of the pelvic examination, the sub-strata of fears about contraception characteristic of many women who reach the clinic, and the high rates of dropouts, much more systematic training of staff in human relations is needed—training both in staff-to-staff and staff-to-patient relations." It is especially important, he emphasizes, to improve staff performance in health agencies (such as hospitals and health departments) where family planning has been added to existing services and is perceived as having "the least medical glamour, with the least relevance to curative medical methods. . . ." Family planning is "likely to get lost in crowded general health clinics," he warns.

• *Boards*. "No systematic and specific efforts at [board member] education have ever been attempted," and the "educational mandate is clear," writes Stycos, when the range of problems policy-making boards must address is considered. These include: how to obtain financial support, what the relationship with government should be, "the need to broaden the base of policy decision-making, the need to explore non-clinical alternatives to contraceptive services, and the need to balance medical and motivational elements in programs." To assist them in grappling with these problems, they should be supplied, Stycos believes, with information about "demographic, economic and environmental implications of . . . family planning programs; comparative family planning approaches around the world; technological advances in birth control techniques and program administration; private resource development methods; and the aims, structure and history of their local programs."

It is important to reach health, education and welfare services professionals, Stycos believes, because of the multiplier effect they can have as disseminators of information. He describes them as only moderately receptive members of the secondary audience group, but believes the effort to reach them with I & E messages is important because of the relevance of family planning to their professional objectives.

Stycos urges concentration on efforts to inform and educate politicians and government officials about family planning since they are important in determining the acceptance or rejection of family planning as an appropriate concern of government and in determining what priority it will have. "Their receptivity to family planning depends both upon its perceived political assets and liabilities, and upon its perceived role in national economic and social development," Stycos points out. He observes that "family planning proponents have tended to sophisticate themselves about the contributions of birth control to long-range development, but have been singularly silent, and possibly naive, on its short-range political advantages . . ." He believes government officials are now open to I & E efforts "if these are intelligently directed."

Just as the messages must be appropriate to the requirements of each group so, too, must there be discriminating use of the various communications media. He believes that printed materials are the most important means for reaching most of the target groups, and that "no first admissions or returning client . . . should leave . . . without specifically designed printed materials aimed at repeating and clarifying what has been said in the clinic, on the one hand, and which can be passed on to husbands and friends on the other."

The aim of all information and education programs, Stycos concludes, is to increase "public demand for services," raise the commitment "of the decision-makers who ultimately determine the supply," and improve "the efficiency and commitment of the family planning personnel who deliver the services."

Source

J. M. Stycos, "Targets, Messages and Media—Family Planning Information and Education in Latin America," paper prepared for the Executive Committee of the Western Hemisphere Region of the International Planned Parenthood Federation, 1973.

Oral Contraceptive Research

Data Link Pill with Gallbladder Disease, Blood Changes; Confirm Embolic Risk, No Cancer Link

Two large-scale studies of the side effects of oral contraceptives—the Boston Collaborative Drug Surveillance Programme and the Kaiser-Permanente Contraceptive Drug Study—have produced new data on the relationship of the pill to gallbladder disease, blood clotting, changes in red blood cell characteristics and pulmonary function. The data also confirm previous findings linking the pill to an increased risk of thromboembolism, a decreased risk of benign breast disease, with no increase in risk of breast cancer.

In the Boston study, reported in *The Lancet,* the methodology used to derive the information necessary for analysis of all the disease entities examined—gallbladder, breast tumor and thromboembolism—was the same. Details concerning the nature, duration and frequency of drug use, as well as the condition for which the drug was prescribed, were obtained from almost all patients between the ages of 20 and 75 admitted to 24 hospitals in the Boston area in the first 10 months of 1972. These data were supplemented by medical histories of each patient. Information on marital status and, where appropriate, parity and menopausal status was also obtained. Diagnoses were recorded following discharge of the patient. Those with preexisting or predisposing conditions for each of the deseases under review were eliminated from the study group, as were those for whom oral contraceptives were either unnecessary or contraindicated. This left 212 women with surgically confirmed gallbladder disease, 43 women who were judged to have idiopathic venous thromboembolism and 121 women with various breast tumors.

The control group consisted of 842 generally healthy women aged 20-44 admitted to the hospitals because of acute illness or for elective surgery. As with the study group, all women were excluded for whom oral contraceptives were contraindicated, who were pregnant or postmenopausal or who had diseases requiring drug therapies which might have interfered with the current study.

Pill and Gallbladder

For the first time, an association was found between increased risk of gallbladder disease and use of the pill. Of 212 women with surgically confirmed gallbladder illness, 65 (31 percent) had used the pill, compared with 170 (20 percent) of the controls. Pill usage ranged from 38 percent of patients 20-24 years old (compared with 29 percent of controls) to 21 percent of patients 40-44 years old (compared with only five percent of the controls).

When standardized by age (since a woman's risk of getting gallbladder disease increases with age, independent of other factors), the investigators found oral contraceptive users ran twice the risk of getting the disease than nonusers. For each age category, a higher proportion of patient pill users than control users had taken the pill for between six months and a year. The investigators noted that apparently most women susceptible to gallbladder disease develop it early during pill use. They estimated that the incidence of gallbladder disease in otherwise healthy women not using the pill was 79 per 100,000 a year, and twice that in users.

The Boston study corroborated British and U.S. findings that oral contraceptive use does not appear to increase the risk of breast cancer. [See: "British, U.S. Studies Find No Link Between Pill Use and Breast or Cervical Cancer," *Digest,* Vol. 2, No. 1, 1973, p. 3.] Three of 23 women with breast cancer, or 13 percent, were taking oral contraceptives—none for more than three years. The youngest of the three was 35. Among the 842 controls, 170 women (20 percent) were pill users, and 17 of them had taken it for *more* than five years. These data, "provide further reassurance that oral contraceptives do not produce a demonstrable increase in breast malignancy in young women."

The data suggest that pill use may, perhaps, have a protective effect with respect to the development of benign breast tumors. Only six percent of 98 patients with these tumors were pill users, compared with 20 percent of 842 controls. "At each age level, oral contraceptive use was less common in those with benign breast tumors," the researchers found, concluding that the risk of benign breast disease was only half as great for women taking the pill as for nonusers.

The program's findings with regard to thromboembolism yielded a higher estimate of the increased risk to pill users than any of the previous studies conducted in the United States, England and Sweden, the investigators reported. The Boston group found that the risk of venous thromboembolism for women taking oral contraceptives increased 11 times over that experienced by nonusers, compared to a tenfold increase found by British investigators, a relative risk of 4.4 estimated by investigators at Johns Hopkins and 4.5 by Swedish researchers. (The Boston investigators estimated that the incidence of venous thromboembolism among nonusers aged 20 to 44 is about six per 100,000.) They noted that their estimate of risk to users may have been higher because publicity concerning the earlier findings may have influenced physicians, "aware that their patients were taking oral contraceptives," to admit such patients to a hospital more readily if thromboembolism were suspected.

They found, as did the previous groups, no correlation between duration of oral contraceptive use and incidence of the disease. The investigators did not have sufficient data, however, to analyze the relationship of estrogen dose to thromboembolism. Previous researchers have indicated that higher doses increase the pill user's risk of developing thromboembolic disease.

Blood Characteristics

Several small but statistically significant changes occur in the blood of women taking oral contraceptives, investigators at the Kaiser-Permanente Contraceptive Drug Study report, basing their data on women undergoing multiphasic screening.

A study of blood samples from 1,133 women revealed that the blood of women taking the pill tends to clot faster and to form firmer clots than that of nonusers, Dr. Irwin R. Fisch, Shanna H. Freedman and Dr. Frederick A. Pellegrin reported in *Clinical Pharmacology and Therapeutics*. Analysis of data from 4,052 women showed that the blood of pill users was slightly more anemic than that of nonusers, Dr. Fisch and Freedman noted in another article in the same journal. In both studies, there was no difference in measurements between past users and never users; and in neither case was there an increase of highly abnormal readings among pill users.

The coagulation measurements (which were taken on 323 current users, 328 past users, 435 never users and 47 women in their first trimester of pregnancy) were made using a technique known as thromboelastography. Whole blood is placed in stainless steel cups, and a stainless steel piston lowered into each cup, one mm from bottom and sides. As the blood begins to coagulate, strands of fibrin (a protein) form and deflect a light beam passed between the piston and cup. The amount the beam is deflected measures clot firmness and the time it takes for specified amounts of coagulation to occur.

The blood of current pill users clotted about ten percent faster than that of nonusers, and the final clot was about five percent firmer. The investigators compared data for women taking oral con-

traceptives with different types and doses of estrogen. For the only one for which they had sufficient data (mestranol), they found no dose effect. But for the same dose levels, they noticed that mestranol produced faster and firmer clotting than ethinyl estradiol, as did sequential pills when compared with combination preparations. However, the researchers noted, these latter findings "can be considered only working hypotheses due to the small sample size in each group." A similar breakdown was done on the basis of progestin, but no difference was found among different compounds or dose levels.

The relationship of these findings to the increased incidence of thromboembolism in women taking the pill is uncertain, the researchers wrote, and they consider the phenomenon "only one small aspect of thrombogenesis." They noted that "it is likely that only a small percentage of individuals in a hypercoagulable state will actually form a significant clot." The fact that "markedly" abnormal readings "were rare in our subjects . . . may be reassuring to women taking oral contraceptives, since it is possible that the minor, but statistically significant, changes . . . are not of sufficient magnitude to initiate thrombogenesis." Other factors, therefore, are probably needed before a thromboembolism can occur. (Hungarian researchers, reporting in the *American Journal of Obstetrics and Gynecology*, found similar thromboelastogram measurements in 35 women using a pill containing 2.5 mg of norethynodrel and 100 mcg of methoxyethyloestradiol.)

Red blood cell measurements were made on 4,052 women, aged 18-60, 1,083 of them current pill users, 1,079 past users, 1,574 never users of the pill and 316 women in the first trimester of pregnancy. Comparisons were made on the basis of groups matched for age and menstrual history since both factors affect red blood cell measurements. For several of these variants, changes were found in pill users, and these alterations were greater in women who had used the pill for five or more years than in those using it for a shorter time.

Hemoglobin, hematocrit (percentage of blood, by volume, made up of red blood cells) and red blood cell count all dropped slightly, but in all cases the drop was much less than that found in pregnant women. Mean cell volume, mean cell hemoglobin and white blood cell count all rose—the latter two less than in pregnancy, the first more than in pregnancy. In general, there was an overall tendency for women on the pill to have fewer but larger red blood cells, a condition which, when actute, is known as macrocytic anemia.

"No case of macrocytic anemia was found," the investigators noted. "Therefore, these [observations], though statistically significant, may have little clinical implication." It is known, they point out, that a deficiency of either vitamin B_{12} or folic acid can cause changes of this type. Other researchers have reported that oral contraceptives can cause lowered levels of both these vitamins in pill users, the Kaiser investigators observe, and this may be the cause of the changes seen. They note that the high socioeconomic level of the women may explain the lack of anemia, because good nutrition may prevent extreme deviations.

Because the pill has been associated with certain side effects which may cause changes in lung capacity (pulmonary embolism, which would adversely affect pulmonary function, and increased levels of an enzyme, antitrypsin, a deficiency of which may contribute to chronic bronchitis and emphysema), Kaiser researchers examined the pulmonary capacity of 2,066 women aged 15-60.

No difference was found among current pill users, former users, never users, women in the first trimester of pregnancy and older women taking estrogen compounds for noncontraceptive purposes, report Shanna H. Freedman and Dr. Neil E. Anderson in the *American Journal of Obstetrics and Gynecology*. The tests were made with a spirometer, which measures the lung capacity and the speed with which air can be expelled from the lungs. Certain factors which affect lung capacity — weight, height, and smoking rates — were found to be the same in all groups. The only critical factor in which the groups differed was age (current and past users tended to be younger than never users), and the data were adjusted accordingly. The investigators concluded that "the results of the present study confirm the absence of any 'pill effect' after consideration of the relevant covariables."

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Georgia Program

Black Fertility Drops When Service Offered

A statewide subsidized family planning program in Georgia is credited with having helped blacks to reduce their fertility sharply within a recent five-year period, even as services from private physicians had enabled whites to reduce theirs prior to the statewide program. The reduction over the 12-year period 1960-1971, for both ethnic groups was similar: 28.0 percent for blacks and 26.8 percent for whites. These findings were presented by Dr. Philip D. Darney of the Family Planning Evaluation Branch of the Center for Disease Control, at the 1973 annual meeting of the Population Association of America.

Georgia's family planning program accelerated at the end of 1965 (although there had been fragmentary services before then). In the five years before its acceleration, the total fertility rate among whites declined by 21.5 percent (from 3.2 to 2.5 children per woman) while among blacks the rate dropped by 12.7 percent (from 4.5 to 3.9 children per woman), a decline only three-fifths as great as among whites. From 1966 to 1971, however, the white rate declined by just 5.3 percent (from 2.3 to 2.2), while the black rate dropped nearly three times as much, from 3.5 to 3.0, or by 15.3 percent. Thus, Darney pointed out, black fertility declined at a higher rate after the program began than before; while white fertility declined at a rate only one-fourth as high as it had before the program.

Darney pointed out that the program could not have had much effect on white fertility, since only six percent of white women of reproductive age had accepted a contraceptive method from the program by the end of 1971, compared to 39 percent of comparable black women.

In the 20 counties in which contraceptive services from the program were accepted by 53 percent or more of black women of reproductive age, black fertility declined by 43 percent between 1965 (before the program) and 1971. In contrast, in the 20 counties in which program services were accepted by 23 percent or less of black women of childbearing age, the fertility rate declined by only 21 percent. In the state as a whole, black fertility declined by 24 percent between 1965 and 1971.

Source

P. D. Darney, "A Statewide Family Planning Program's Effect on Fertility," paper presented at the annual meeting of the Population Association of America, New Orleans, La., April 27, 1973.

A Glossary of Family Planning Terminology

The following glossary of family planning terms was approved by the National Family Planning Forum last May. It was developed by the Forum's Committee on Terminology, chaired by Dr. Louise B. Tyrer, project director of the Family Planning Division of the American College of Obstetricians and Gynecologists. Committee members include Dr. Lee Davis, Associate Professor of Obstetrics and Gynecology at the New Jersey College of Medicine and Dentistry and associate director of the Newark Family Planning-Maternity and Infant Care Projects; Dr. Theodore Scurletis, chairman of North Carolina Statewide Family Planning; Dr. J. King B.E. Seegar, chief of the Maternity and Family Planning Section of the Maryland State Department of Health and Mental Hygiene; and Frederick S. Jaffe, director of the Center for Family Planning Program Development, the technical assistance division of Planned Parenthood-World Population.

The glossary was compiled in order to standardize definitions of terms commonly used, but often differently defined, by family planning workers. Such standardization, in the Forum members' belief, is needed for communication, within and among programs, to facilitate program management, monitoring, evaluation, cost analysis and accounting. As an introduction to the glossary, the committee set forth a "paradigm of voluntary family planning."

According to the paradigm, the *mission* of family planning is to enable people to have the number of children they want when they want them; the *goal* of family planning programs "is to provide comprehensive family planning services to all coitally active fertile women who are not pregnant and to their partners." All sexually active, fertile men and women comprise the *universe of need*; those individuals currently using effective family planning methods constitute the *met need*; all others make up the *unmet need*. An objective of the program is to enable individuals in the latter category to secure adequate service either from private physicians or organized programs. Services provided through either source may be paid for in whole or in part by the patients themselves, by private health insurance or by public funds. In addition, organized programs may be financed in part by private contributions. Organized programs provide subsidized services for the indigent, the medically indigent and for those for whom services would not otherwise be available.

It is pointed out that the techniques available for fertility regulation, some or all of which may be offered by any particular provider, include infertility diagnosis and treatment, abortion and sterilization as well as contraceptive services. The paradigm concludes by detailing the health, personal and societal benefits of family planning and emphasizes that "achievement of effective utilization of fertility regulation is a critical step towards personal self-fulfillment."

The glossary is divided into five main sections:

- general terminology,
- definitions of categories of family planning patients,
- definitions of categories of family planning visits,
- consumer participation in family planning, and
- medical terms

The first four of these are arranged conceptually while the last section is ordered alphabetically.

General Terminology

Family Planning

Voluntary planning and action by individuals to have the number of children they want, when and if they want them.

Fertility Regulation

Medical and nonmedical techniques that enable individuals to engage in voluntary planning and action to have the number of children they want, when and if they want them. These techniques include contraception, infertility diagnosis and treatment, abortion and sterilization.

Population Planning

Organized efforts to analyze population variables with respect to size, rate of growth (or decline), distribution and composition, and their impact upon society as a whole, and to recommend and implement measures relating to these variables so as to optimize what is generally termed, the "quality of life" for all people.

Family Planning Agency

An administrative mechanism to carry out family planning programs through family planning projects which deliver family planning services.

Family Planning Programs

Activities that provide the services which enable individuals effectively to practice family planning. These activities are provided by commercial, governmental, or nonprofit institutions and individual practitioners.

Family Planning Project

A specifically designed set of activities and services intended to advance achievement of the program's family planning objectives. It may be funded through general revenue or specific grants from either public or private sources.

Family Planning Services

Services which provide the means to enable individuals to meet their family planning objectives. These services are medical, social and educational.

Medical Family Planning Services

Medical history, physical examination, laboratory testing, consultation, counseling, treatment, including continuing medical supervision, issuance of drugs and contraceptive supplies and appropriate medical referral when indicated. Medical services for family planning include:

- *Complete medical history* at initial examination, and interim history at subsequent visits.
- *A physical examination* for initial visits and annual examination visits.
  - Thyroid palpation
  - Inspection and palpation of breasts and axillary glands, with instruction to the patient for self-examination
  - Auscultation of heart and lungs
  - Blood pressure
  - Weight
  - Abdominal examination
  - Pelvic, including speculum, bimanual and rectovaginal examinations
  - Extremities
  - Others as indicated
- *Examination and laboratory testing for revisits* as indicated.
- *Laboratory testing for initial visits* and annual examination visits.
  - *Minimal testing*: (1) Hematocrit or hemoglobin (2) Urinalysis (miscroscopic examination when medically indicated) (3) Papanicoulaou smear (4) Venereal disease testing (serology and GC culture) (5) Pregnancy testing when indicated
  - *Optional testing* when medically indicated or financially feasible: (1) Sickle cell screening, (2) Other medically indicated tests
- *Consultation*, including diagnosis, counseling and prescription:
  - Contraception
  - Infertility
  - Sterilization
  - Related medical problems (including pregnancy)
- *Referral* to other providers for medical conditions not treated in the program.

Social and Educational Family Planning Services

These services comprise:

- *Outreach and follow-up*
  - Identification
  - Location
  - Contact
  - Discussion
  - Appointment for family planning services
  - Referral to other agencies for social services
- *Facilitation services*
  - Transportation
  - Babysitting
  - Nonmedical counseling when necessary
  - Inclinic instruction and discussion
- *General community information* and educational activities through all media to all types of community institutions and individuals. These activities should include family life, human sexuality, and health education; social and demographic rationales for family planning, in addition to information concerned with the specifics of contraceptive methods.

Family Planning Clinic

A place or facility at which an agency provides medical family planning services. It may be a hospital, a health center, a mobile unit, a freestanding site, church or storefront. Physicians' offices should be considered as clinic locations only when there is a formal relationship with an agency. An agency may operate one or more family planning clinics.

Family Planning Clinic Session

A scheduled period of time during which family planning services are provided at a clinic location. The clinic session may be *specialized* where only services related to family planning are provided, or *combined*, where family planning services are offered in conjunction with other health services such as maternity, postpartum, well baby, pediatric, gynecologic, or comprehensive health care.

Outreach

Activities which inform prospective patients of the availability of family planning services, assist them in availing themselves of the services, and schedule and maintain them in the continuity of the program. They consist of several distinct processes, namely: recruitment, referral, follow-up and education. Outreach activities may be classified as direct and indirect.

Direct Outreach Activities

These include the activities of recruitment, referral and follow-up.

- *Recruitment* attempts to locate and identify prospective patients, to interview them and discuss their needs, to provide them with information and education; and, if desired, to offer clinic

appointments. It may be done by contacting individuals in hospitals and at maternity and other clinics, by home visiting, at meetings of different community groups, and a variety of other ways.

- *Referral* includes the referral of prospective patients to family planning clinics by other agencies, referral of family planning patients to other medical and social agencies to meet their needs and transfer of family planning patients from one family planning clinic to another, either within the same agency or to another agency.
- *Follow-up*
  This may be accomplished by telephone calls, letters, and home visits to persons who have missed appointments, and should result in rescheduling of appointments. Follow-up may also involve repeated contact between the program personnel and patients for purposes of continuing educational activities and reappointment. (Recruitment and follow-up services may include services which facilitate clinic attendance, such as transportation and babysitting.)

Indirect Outreach Activities

- *Education*
  Indirect outreach consists of varied informational and educational activities undertaken by the program for the purpose of informing prospective patients about family planning. It may be carried out through publicity, i.e., use of radio, the press, and TV, distribution of literature, lectures and presentations to community groups; and, by more formal methods, such as participation in the teaching programs of various school systems.

Medical Indigence in Family Planning

A medically indigent individual is one who is not eligible for welfare, but for whom the cost of average medical care is precluded, or for whom it would create a great hardship, and therefore, be likely to deter the person from utilizing a particular health service.

Definitions of Categories of Family Planning Patients

Prospective Family Planning Patient

Any individual at risk of unwanted pregnancy, or who desires pregnancy but is unable to conceive, and is not securing family planning services.

Appointed Family Planning Patient

A patient who has a family planning appointment.

Family Planning Patient

An individual who receives medical family planning services at a clinic location or other service unit of a program.

New Family Planning Patient

One who receives medical family planning services in a particular program for the first time and is then entered into the program record system.

Continuing Family Planning Patient

A patient who is enrolled in an earlier year, and returns for the first visit in the subsequent reporting year.

Active Family Planning Patient

One who is up-to-date in terms of the last appointment plus a grace period of three months.

Overdue Family Planning Patient

An active family planning patient who has missed a regularly scheduled appointment (synonymous with delinquent).

Inactive Family Planning Patient

An individual who previously registered and received medical family planning service and who is identified as temporarily not in need of family planning services, i.e., pregnant patients and sexually inactive patients.

Closure Family Planning Patient

A patient who is more than three months overdue for the last scheduled appointment and is not classified as "inactive" (synonymous with *terminated*, *dropouts*).

Readmission Family Planning Patient

Any patient who has been classified as a closure from a program and who subsequently returns to the program and for whom records are available.

Transfer Family Planning Patient

Any patient who moves from one clinic to another.

Transfer—Within System

Any patient who receives medical family planning services from a clinic and is enrolled in the data system, and who moves from one clinic to another clinic within the same data system.

Postpregnant Family Planning Patient

A patient who registers in a family planning program and receives medical family planning services for the first time within 56 days of having delivered products of conception. This may take place in the hospital immediately after delivery, or at the postdelivery checkup examination in a clinic. This category includes postpartum and postabortal patients.

Total Family Planning Patients

The sum of active patients, closure patients, and inactive patients for the reporting period.

Contraceptive Patient

A patient who is actively and consistently using a medically acceptable contraceptive method.

Infertility Patient

One who is receiving medical infertility diagnosis and treatment. An infertility patient is classified as a Family Planning Patient.

Other Patients

Any patients who receive a medical service other than pregnancy or venereal disease testing at a family planning clinic location, or other service unit of a program, who are not at risk of pregnancy or active contraceptors. This covers the following three categories:

Post-Family Planning Patient

An individual who continues to attend the clinic and receive some medical services, but no longer needs contraception, pregnancy termination, sterilization or infertility services. Included in this group are:

- *Postmenopausal patients*
- *Tubal sterilization patients*
- *Hysterectomy patients*
- *Patients sterilized by other procedures*

Medical Patients (miscellaneous)

Individuals who receive any medical services through the program or clinic and who are not classified in other patient categories. (Individuals receiving pregnancy or VD tests may be enumerated as "encounters" but the recordkeeping system should reflect their numbers and demographic characteristics.)

Counseling Patient

An individual who receives professional medical or social service guidance regarding contraception, infertility, pregnancy termination, sterilization, or related health and social problems from a doctor, nurse or other personnel specifically trained to conduct such a discussion in the clinic; and who does not receive a medical service (except pregnancy testing or VD testing).

Male Patients

Male patients should not be counted with other active family planning patients, but should be separately enumerated. Service for male patients may consist of:

- *History and physical examination* in conjunction with the services listed below
- *Vasectomy*
- *Contraceptive services*, e.g., condoms
- *Medical services*, e.g., VD or infertility
- *Counseling*

Definition of Categories of Family Planning Visits

Initial Visit

A visit at which the patient is registered, receives medical family planning services from the program for the first time, and is entered into the record system.

Enumeration Visit

Note: The reason for including the category of 'Enumeration Visits' is to simplify the task of obtaining a 'prime patient' count (an unduplicated count of individuals) for a given reporting period. This category would be unnecessary if, for example, a computer program were written in such a fashion as to scan automatically, for prior attendance, all visits in the reporting period for each particular patient identification number. This category is also probably unnecessary in projects which have only one clinic location, a light patient load, and a limited number of sessions. Under these circumstances, a 'hand tally' system would be easy to maintain, particularly if personnel turnover were minimal.

Enumeration—New Family Planning Patients

The sum of all initial visits during the reporting period (symbolized by E_n).

Enumeration—Continuing Family Planning Patients

The total of all first revisits by patients registered in the previous reporting period which occurred during the current reporting period (symbolized by E_c).

Total Family Planning Patients

The sum of enumeration visits of new patients plus enumeration visits of continuing patients. (Total patients = $E_n + E_c$.)

Annual Examination Visit

A visit made by continuing patients yearly, within three months of the patient anniversary date, at which time the patient receives at least the minimally recommended medical family planning services (synonymous with *annual visit, annual revisit*).

Revisit

Any visit during a reporting period by a previously registered patient other than the annual examination visit or supply visit, and at which time the patient sees authorized personnel. Revisits consist either of routine scheduled visits or nonroutine visits for the resolution of unanticipated problems.

Supply Visit

A visit by a previously registered patient for obtaining prescription supplies only. (If supply refills are mailed, they should be enumerated separately.)

Total Visits

The sum of all visits by all patients during the reporting period (i.e., initial, annual examination, revisits and supply visits, including the enumeration visit for continuing patients).

Encounter

A contact between a client and a provider of family planning services. The client may or may not be a family planning patient. The encounter may take place in the clinic, outside the clinic, or by telephone. Examples of encounters include: group sessions held for general discussion, lectures, films, a visit to a clinic whose sole purpose is to pick up nonprescription supplies, contact by an outreach worker, response to a telephone inquiry, incidental medical testing, such as pregnancy or VD testing. (Persons receiving such medical services may be classified as encounters, but their sociodemographic characteristics should be obtained and they should be enumerated in the category of *Other Medical Patients–Misc.*) If a person receives counseling of an informative nature, but does not receive any medical services, adopt a contraceptive method, or make a future appointment, the contact is classified as an 'encounter'. For reporting purposes, a 'clinic visit record' is not completed for an encounter. Encounters are tabulated separately.

Consumer Participation in Family Planning

Community

The population in the geographic area served by a particular family planning program.

Consumer

A current or past user of the services of a particular family planning program.

Consumer Participation

The act of organized participation in the affairs of a family planning program by consumers or consumer representatives.

Consumer Representative

Any member of the community who is selected to present and support the interests of those who utilize the services of a family planning program. This representative may or may not be a consumer.

Advocate

Any individual or group which seeks to speak for and advance the interests of a particular person or group. Examples are consumers, community representatives and professionals.

Consumer Advocate

Any member of the community who supports and seeks to advance the interest of those who utilize the services of a family planning program.

Family Planning Consumer Advocate Organization

An organized group, one of whose purposes is the representation of the family planning consumer, i.e., welfare rights organizations or community action agencies. The group may be formally selected by the family planning consumers as their representative.

Advisory Action

Positive and/or negative recommendations on a particular decision or course of action.

Advisory Board

A group of individuals, appointed or elected, who interface with each other, and whose functions are to receive and secure information on particular aspects of the program for the purpose of giving advice to the agency or program, e.g., consumer advisory board, patient advisory board, medical advisory board.

Policy

A definite course of action selected from among alternatives to guide and determine present and future decisions, both programmatic and fiscal.

Policy Board

A group of individuals, appointed or elected, whose function is to determine policy for the agency or program. All agencies have some type of policy board, e.g., board of directors, board of trustees, governing body, board of health.

Medical Terms

Abortion

Expulsion or extraction of all (complete) or any part (incomplete) of the placenta or membranes, without an identifiable fetus or with a liveborn infant or a stillborn infant weighing less than 500 gm. In the absence of known weight, an estimated length of gestation of less than 20 completed weeks (130 days or less), calculated from the first day of the last normal menstrual period, may be used. Abortion is a term referring to the culmination of the birth process before the twentieth* completed week of gestation.

Abortion, Complete

Expulsion of all the products of conception before the twentieth* completed week of gestation.

Abortion, Incomplete

Expulsion of some, but not all, of the products of conception before the twentieth* completed week of gestation.

Abortion, Induced

Deliberate interruption of pregnancy by any means before the twentieth* completed week of gestation. It may be therapeutic or nontherapeutic.

Abortion, Infected

Abortion associated with infection of the intra-abdominal genital organs. (If infection is disseminated into the systemic circulation, this becomes a septic abortion.)

Abortion, Missed

Abortion in which the embryo or fetus dies in utero before the twentieth* completed week of gestation, but the products of conception are retained in utero for eight weeks or more.

Abortion Rate

(Total number of abortions during period/Total number of females 15-44 during period) x 1,000.

Abortion Ratio

(Total number of abortions during period/Total number of live births during period) x 1,000.

Abortion, Spontaneous

Expulsion of the products of conception before the twentieth* completed week of gestation without deliberate interference. (Also known as "miscarriage.")

Abortion, Therapeutic

Legally induced abortion before the twentieth* completed week of gestation.

Abortion, Threatened

State in which bleeding of intrauterine origin occurs before the twentieth* completed week of gestation, with or without uterine cramps, without expulsion of the products of conception, and without dilatation of the cervix.

Afterbirth

Placenta and allied membranes cast or removed from the uterus after the birth of a child.

Age-Specific Fertility Rate

(Total number of live births during year to female of age x/Total number of females of age x as of July 1 of the same year) x 1,000.

Amenorrhea

Absence of the menses.

Amniotic Sac

Fluid-filled sac that surrounds the embryo.

*The gestational age criterion of abortion is primarily a legally oriented definition, while the weight criterion is primarily a medically oriented definition.

Androgen

Hormones that produce masculine characteristics.

Bartholin's Glands

Two secreting glands found at either side of the vaginal entrance; also known as greater vestibular glands.

Bulbourethral Glands (Cowper's)

Tubular glands that secrete into the male urethra.

Castration

Removal of the gonads.

Cervix

Lower segment of the uterus, a portion of which extends into the upper portion of the vagina.

Chancre

Ulcer or sore caused by the syphilis spirochete.

Chancroid

Sexually transmitted disease of the genitalia, in which painful lesions develop and local lymph nodes are generally enlarged.

Circumcision

Surgical procedure in which the foreskin of the penis is removed.

Clitoris

Small erectile body in the female that is situated at the most anterior portion of the vulva between the labia. It is responsive to sexual stimulation.

Coitus

Heterosexual relationship with entry of the penis into the vagina.

Coitus Interruptus

Withdrawal of the penis prior to ejaculation. (It is considered a poor method of contraception.)

Conception

Implantation of the blastocyst. Not synonymous with fertilization (from *Obstetric Gynecologic Terminology*, American College of Obstetricians and Gynecologists).

Condom

Sheath worn over the male penis.

Continence (Abstinence)

Refraining from sexual activity.

Contraception

Conscious use by individuals of medically prescribed and/or nonprescription methods that permit coitus with reduced likelihood of conception (commonly known as birth control).

Copulation

Sexual intercourse.

Couvade

Psychological reaction in which men experience many of the symptoms of pregnancy.

Crude Birth Rate

(Total number of live births during year/ Total population as of July 1 of the same year) x 1,000.

Cryptorchidism

Undescended testes.

Diaphragm

Dome-shaped device worn over the cervix and used as a contraceptive.

Douche

Cleansing the vagina with a liquid. Not considered effective as a contraceptive method.

Dysmenorrhea

Painful menstruation.

Ectopic Pregnancy

Extra-uterine pregnancy.

Ejaculation

Expulsion of the semen from the penis.

Endometrium

Lining of the uterus.

Epididymis

Convoluted tubule connecting the testis to the vas deferens and located on the testis.

Estrogen

Female sex hormone produced by the ovaries.

Fallopian Tubes

Two hollow muscular passages that transport ova from the ovaries to the uterus.

Fertilization

Union of the male sperm cell and the female ovum.

General Fertility Rate

(Total number of live births during year/Total number of females 15-44 as of July 1 of the same year) x 1,000.

Foreskin

Retractable fold of skin found over the head of the glans penis; also termed the prepuce.

Gonads

Testes or ovaries; sex glands.

Gonococcus

Bacterium that causes gonorrhea.

Gonorrhea

Sexually transmitted disease caused by gonococcus.

Gravid

Pregnant.

Gynecology

Medical science that deals with the prevention or treatment of disorders of the female reproductive system.

Hydrocele

Condition in which fluid collects in the scrotum.

Hymen

Membrane that partially covers the entrance to the vagina.

Hysterectomy

The operation of excising the uterus, performed either through the abdominal wall or the vagina. This does not include the removal of the tubes and ovaries. Hysterectomy is a medically accepted method of sterlization.

Infant Death Rate

(Number of deaths of children under 1 year of age during year/Total number of live births during year) x 1,000.

Infertility

Diminished or absent ability to conceive.

IUD (Intrauterine Contraceptive Device)

Device inserted into the uterus to prevent pregnancy.

Leukorrhea

Excessive vaginal discharge.

Libido

Sexual drive.

Live Birth

Birth of a fetus, irrespective of its gestational age which, after complete expulsion or extraction from the mother, shows evidence of life—that is, heartbeats or respiration.

Maternal Death Rate

(Maternal deaths during period/Number terminated pregnancies during period) x 100,000 (from *Obstetric and Gynecologic Terminology*).

Medical Backup for Family Planning

Outpatient and inpatient services, at an adjacent hospital or medical facility, available to take care of medical referrals from a family planning clinic, as well as emergencies arising from contraceptive use, which should be arranged through a binding agreement. A necessary part of a family planning program.

Medical Supervision in Family Planning Programs

Continuing physician supervision of medical aspects of the program, including physician surrogates functioning in a family planning program. Necessary for all family planning programs and clinics.

Medically High-Risk Family Planning Patient

Two categories of patient: (1) Those for whom pregnancy would be particularly undesirable because of guarded maternal or fetal prognosis; (2) Those for whom one or more methods of contraception are associated with increased risk.

Medically Uncomplicated Family Planning Patient

Patient who has no medical problems requiring referral to other medical facilities for evaluation and/or care, and who has no medical contraindications to any type of contraception.

Menarche

First menstrual flow; usually occurs between 10 and 14 years of age.

Menopause (natural)

Transitional phase in a woman's life when menstrual function ceases as a result of declining ovarian function due to aging of the ovaries. It usually occurs between 40 and 50 years of age.

Menorrhagia

Excessive bleeding at the time of menstrual flow.

Metrorrhagia

Uterine bleeding occuring at irregular intervals.

Neonatal Mortality Rate

(Number of deaths of infants under 28 days of age during year/Total number of live births during year) x 1,000.

Nulliparous

Never having given birth to a child.

Obstetrician-Gynecologist

Physician specializing in the care, treatment and delivery of pregnant women, and treatment of disorders of the female reproductive system.

Oligomenorrhea

Infrequent menses.

Orgasm

Height of sexual excitement.

Ovaries

Two ovoid structures on each side of the pelvis just below the distal end of the fallopian tubes. They measure about 3.5 cm in length, 2 cm in width, and about 1.5 cm in thickness. The ovaries are the primary source of female hormones and produce ova.

Ovulation

Expulsion of the female germ cell from a ruptured graafian follicle in the ovary.

Ovum

Female reproductive germ cell.

Penis

Male copulatory organ.

Perinatal Mortality

(Number of still births plus number of neonatal deaths/Number of stillbirths plus number of live births) x 1,000 (from *Obstetric Gynecologic Terminology*).

Post-Neonatal Mortality Rate

(Number of deaths of children from 28 days to one year/Total number of live births during year) x 1,000.

Pregnancy

State of a female after conception and until termination of gestation.

Pregnancy Termination

Expulsion or extraction from the mother of the products of conception.

Prostate

Gland in the male which surrounds the neck of the bladder and urethra, and whose secretions are a component of the semen.

Rhythm Method

Method of contraception in which the partners refrain from intercourse during the fertile period.

Semen

Thick yellowish-white fluid which normally contains the male reproductive germ cells, and is released at the time of ejaculation.

Seminal Vesicles

Two sacculated, glandular structures which are diverticula of the vas deferens. They are located behind the prostate. Their secretion is one of the components of semen.

Sexual Intercourse

An encompassing term indicating all forms of sexual relations.

Sperm

Male reproductive germ cells.

Spermicide

Chemical substance that inactivates sperm.

Sterility

Absence of the ability to conceive.

Sterilization

Any surgical, chemical or radiological procedure by which an individual is made incapable of reproduction.

Stillbirth

Death prior to the complete expulsion or extraction from its mother of a product of conception, of 20 weeks gestation or more, or weighing more than 500 grams. The death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Stillbirth Rate

(Total number of stillbirths during year/Total number of live births and stillbirths during year) x 1,000.

Stillbirth Ratio

(Total number of stillbirths during year/Total number of live births during year) x 1,000.

Syphilis

Sexually transmitted systemic disease that may cripple or kill.

Testes

Male gonads; egg-shaped glands, normally situated in the scrotum, which produce male hormones and sperm.

Testosterone

Male sex hormone produced by the testes.

Tubal Sterilization

Any surgical or chemical procedure by which the patency of the fallopian tubes is interrupted.

Urethra

Tubular structure that provides for the outflow of urine from the bladder. In the female, it is situated close to the anterior vaginal wall; and in the male, in the penis.

Uterus

Hollow, muscular, pear-shaped organ located in the pelvis between the bladder and rectum. The cervix forms the lower portion of the uterus.

Vagina

Hollow muscular structure in the female extending from the cervix to the vulva.

Vas Deferens

Hollow, muscular tube by which the semen, including the sperm, are transported from the testis to the penis to be ejaculated.

Vasectomy

Surgical procedure by which the patency of each vas deferens is interrupted.

Vulva

External female anatomy which includes the labia majora, labia minora, and clitoris.

X-Chromosome

Female sex chromosome.

Y-Chromosome

Male sex chromosome.

Credits

pp. 1, 5: Ken Heyman; p. 3: Charles Harbutt, Magnum.

Resources in Review

by Dorothy L. Millstone

Although there is now a large body of medical and scientific data concerning the various contraceptive methods, there is no central source to which health educators can turn for definitive answers to questions which may arise. There are numerous areas of disagreement among experts themselves. Opinions vary, for example, regarding precisely how long contraceptive jelly remains effective once it is inserted. There are varying directions on which, and how many, surfaces of a diaphragm should receive the spermicide. Some experts are convinced of the long-term efficacy of frozen sperm, others are dubious. Little wonder, then, that educational materials produced to describe and explain the contraceptive methods often vary widely.

Many of the better teaching resources point out the variations and repeat them without comment. This frees the author of bias, but it places the burden of making judgments on the reader who may be entirely without the background necessary to make informed choices. Until a higher level of standardization is achieved in the family planning field, the teacher or group leader will have to be vigilant in identifying the variations and in directing students to a decision in harmony with institutional or clinic standards.

Some Examples

How soon does the pill protect against pregnancy? Some texts reply: immediately. Others recommend combining pills with another method for one menstrual cycle. Some give both answers and don't indicate a preference. How should the patient be taught about the pill's side effects? Some handle this statistically and reassuringly. Few warn specifically: think 'pill' if you get a pain in the leg; if you develop skin trouble; if you get a long-lasting headache; if your eyes hurt. Think 'pill' if anything unusual hurts. Ask the doctor. It may not be pill-related, but it is best to check. Many rely mainly on the warning included under Food and Drug Administration (FDA) mandate in every pill packet and they don't stress patient education in symptom recognition at all.

Professional Education

• *Family Planning Education* (1973), by Charles William Hubbard, a Florida health educator, is a new and, on the whole, quite commendable teaching tool which spurs this reminder about lack of standardization in family planning information and procedures. This 173-page paperback, designed for workers in the health-oriented professions, deals comprehensively with contraception, sterilization, venereal disease and related issues. A glossary defines and spells out scientific terms phonetically. Sources are provided conveniently in footnotes close to related text. Supplementary reading is suggested. An appendix explains what many books neglect: how to understand birth control method evaluations figured in "hundred woman-years," how to calculate fertility rates, and how these differ from the rate of natural population increase.

In the hands of a competent teacher, this could be a good text for schools of nursing, public health, medicine and hospital public health professional staff orientation, and, possibly, college physiology and hygiene classes. But the author does not resolve controversial questions, he just mentions them.

For example, in the section on intrauterine methods, closed devices are described as "often not a first choice," but the fact is that they are no longer prescribed by most physicians and Planned Parenthood's medical department has advised its clinics not to use them at all. Publication predated the FDA seizure of the Majzlin spring. The spring is mentioned as though the device could still be readily obtained.

Suggestions to the counselor advising a patient considering an IUD are thoughtful and far-reaching. But comparable material counseling those considering the pill is more academic, less concerned with questions likely to affect the patient.

The reader learns that specialists don't agree about how to use the diaphragm. Some say it can be inserted up to eight hours before the sex act and still be effective; others would limit the effective period to two hours, with the recommendation to add more spermicide if the interval is longer. Again, discussing vasectomy, the author points out that some experts claim freezing sperm would permit men who choose sterilization to become fathers later. But he mentions also the warnings of the American Public Health Association that frozen sperm may not prove viable for fertilization over long periods. The book stresses that the right to parenthood should be protected and "the socially functional retardate should never be coerced into submitting to sterilization," but a special section on sterilization and "free choice" examines only obstacles in the path of those who want surgery and ignores the danger of coercion or compulsion. Despite its shortcomings, this can be a good resource for teaching professionals and paraprofessionals.

Purchase price, $3.55, from your local bookseller or C.V. Mosby Co., 11830 Westline Industrial Dr., St. Louis, Mo. 63141.

• Because it breaks new ground and points a way to meet an important unmet need, *Guidelines for Planning a Training Course on Human Sexuality and the Retarded* (1973), by Winifred Kempton, M.S.S., commands attention. More often than not the mentally retarded are sexually normal, but few teaching materials have been developed to prepare parents, doctors and staff who work with retardates to take this fact adequately into account. Moreover, for most of history, birth control methods could not be used effectively by retardates and sterilization was long the accepted solution.

The title of this 132-page paperback is about right. It is not a curriculum and it is not a book of resources, although it contains many of the latter and suggests more. It is an approach to self-education for professionals and parents so that they can set up courses and train themselves and others.

Mrs. Kempton, a Planned Parenthood affiliate educator, has worked with retardates in institutions and has conducted courses for parents and professionals in just this area. Her text is drawn from her experience.

One of eight one-day teaching sessions suggested is focused on birth control. Films and books are recommended. A teaching format is proposed, using doctor, nurse or social workers, pregnancy counselor and specialist in sterilization.

This is not the last word in its chosen field. Much could and probably will be improved in future editions. Although an introduction states explicitly that sterilization is no longer the only applicable method of birth control, little space is given to the pill or the intrauterine device. The background material about U.S. attitudes toward sterilization comes from the 1965 National Fertility Study (NFS), although the 1970 NFS, now available, with its evidence of much wider acceptance of sterilization, is more current. An historical section regrettably associates sterilization with castration ("in early times"), but the author does point out elsewhere that in modern use sterilization in no way hampers sexual enjoyment. Despite the handicaps, this book has much to offer.

Guidelines is published by the Planned Parenthood Association of Southeastern Pennsylvania and is sponsored, in addition, by the Philadelphia Council on Sexuality and the Physically and Mentally Handicapped and a variety of other health and social service agencies.

Cost is $3.50, plus 50c for mailing. Order from Education Department,

Planned Parenthood Association of Southeastern Pennsylvania, 1402 Spruce St., Philadelphia, Pa. 19102.

• For the same professional audience a new movie, *Contraception* (23 minutes), will be a welcome acquisition.

This film (available both in 16 and Super 8 mm cassette) skillfully combines film strip and movie techniques in teaching contraceptive methods. Its high quality professional production helps hold audience interest. Reproductions of interesting and largely ancient art reinforce the impact of a briefly narrated history of contraception. Diagrams are clear and meaningful, not merely illustrative. Condom, diaphragm, pill, rhythm, intrauterine devices and sterilization are explained. Graphics and live photography depict vasectomy and tubal ligation. After each method has been introduced, two doctors discuss its advantages and disadvantages. Although the doctors lack professional stage presence, their dialogues help maintain viewer interest because they add variety in voice and view. The tone is straightforward and the content is informative. The film could be seen two or three times without boring its audience.

Its treatment of oral contraception could be improved by explicit mention of serious, but statistically rare, side effects as well as warnings to users about symptoms to watch for. Its teaching of sterilization as a permanent form of contraception is weakened by the fact that the vasectomy patient in the film is exceptionally youthful and hence far from typical.

The producers list high schools among expected audiences for this film. This seems unlikely. Closeup photography of method insertions and the like will probably prove too explicit for most principals and teachers. But it is worth checking. The film is part of a four-film human sexuality series. The other three are: *Achieving Sexual Maturity* (21 minutes); *The Sexually Mature Adult* (16 minutes); and *Venereal Diseases* (17 minutes).

Contraception costs $275 in 16 mm and can be rented for $25; in Super 8 mm the purchase price is $240. If all four films are purchased in 16 mm, the price is $800; in Super 8 mm, the price for four is $775. Preview prints are available for faculty or professional screening. Available from John Wiley and Sons, Inc., 605 Third Ave., New York, N.Y. 10016 or the Wiley representative in your area.

Materials for Teenagers

Reaching and teaching teenagers is the major goal of several interesting new materials.

• *The Inside Story* (1973), a colorful, lighthearted 7 ″ x 8½ ″ pamphlet, issued by Planned Parenthood of Chicago, is a family planning method manual. Male-female anatomy and the physiology of reproduction are covered briefly; then the text moves on to methods. Tone is indicated by the section heading, "Alternatives to abstinence or how to make love not babies." Illustrations are clear and plentiful. Spermicidal jellies, creams and foams are listed by trade name, making it easier for young people to find them at the drugstore.

The content of this booklet was drawn from three years' experience with teen clinics. As a result, there is much in it often missing from more traditional manuals. For example, in dealing with the birth control pill, emphasis is placed on the necessity for a medical examination and for each individual to use only her own prescription, and never to borrow or lend pills. However, the young reader is not told of specific side effects associated with the pill or of contraindications to its use. Neither is she guided to recognize certain symptoms which may develop. Lamentably, the pamphlet has no table of contents, no pagination and is undated.

This booklet has additional fillips of interest, among them: a section on rape and what to do if it happens; advice on how to tell if you might be pregnant and how to get a test to make sure; a list (surely unique!) of illegal methods of abortion marked by skulls and crossbones and described as dangerous and death-causing; and a directory of Chicago agencies listing resources for prenatal care, adoption and maternity homes for the pregnant.

One free copy can be obtained by writing to Leslie Library, Planned Parenthood Association of Chicago Area, 185 N. Wabash Ave., Chicago, Ill. 60601.

• Experience with teenagers also dictates the format of *Wouldn't It Be Better to Know?* (November 1972; revised 1973), prepared by the staff of Operation Total Family, a family planning counseling service sponsored jointly by New York City's Harlem Hospital and Harlem Neighborhood Association. Its modest dress (mimeographed 8½ ″ x 5¼ ″ strips of colored paper, held together by a large fastener) has two advantages: It is cheap and it is flexible. Some 17 topics are discussed and they are differentiated by the color of the paper; the table of contents is color-keyed as well. This permits outreach workers to separate out the family planning teaching materials—to prepare a teaching session, for example. The teacher can easily duplicate certain pages of text or diagrams for an entire group, if needed; and additional matter can be inserted as circumstances require.

Sex education and contraception get major attention in this teaching tool, which is being used in public and parochial schools and in settlement house groups. Birth control pill instruction is confined to the one product used in the Harlem clinic to which this booklet refers (it happens to be the pill taken every day with placebos for the seven days other combinations just skip).

Teenagers might be able to read some of this text without help, but the level is uneven. In addition to text on the physiology of reproduction and family planning methods, the set includes instruction about adolescent development, options facing those with an unwanted pregnancy, guidance about vaginal discharges and education about venereal disease and sterilization.

For a free copy write to Celindia K. Carroll, Coordinator, Operation Total Family, P.S. 139 Center, 140 West 140 St., Room 211, New York, N.Y. 10030.

In or Out of School

Facts About Sex (revised, 1973, John Day Company, New York) is tailor-made for adolescents. Author Sol Gordon, a clinical psychologist and Syracuse University professor, shaped its content to answer head-on the questions young people most frequently ask. Its reading time is 20 minutes. Family planning is discussed in a section called "Prevention of Pregnancy." Methods are named, briefly described and shown in pictures. The artwork throughout is not only illustrative, but endows the text with grace. The author wins adolescent interest by writing plainly, using street terms along with scientific vocabulary and limiting his explanations drastically. He combines fact (taking one or two pills will not prevent pregnancy) with strongly held personal convictions (premarital sex "is seldom satisfying and can result in sexual problems").

Cost is $1.90 for the paperback and $3.95 for the hardcover edition. Order from bookstores.

Note—Readers are urged to send their own materials for review. Send two copies of each item; define the intended audience and goal; state the price and how *Digest* readers may obtain copies. Contributions should be addressed to:

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Family Planning Digest
Room 12A-27
5600 Fishers Lane
Rockville, Md. 20852

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Family Planning Digest
The Bureau of Community Health Services
Health Services Administration
U.S. Department of Health, Education and Welfare
5600 Fishers Lane, Room 12A-27
Rockville, Maryland 20852

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HEW 396

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•U.S. GOVERNMENT PRINTING OFFICE: 1973—0—734-441

DHEW PUBLICATION NO. (HSA) 74-1600